

SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

Recommendations for Outpatient Care

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Physicians know that ill health is the result of social factors as well as genetics, so the impact of inequality, especially as it pertains to race and ethnicity, has become a growing concern. Dealing with disadvantaged patients in the outpatient setting creates strains because of the extra time required by the patient not only during a visit, but afterward – coordinating care, completing the chart, and finalizing billing promptly.

With time so limited, sometimes we must choose between taking the extra steps to care for all patients more equitably, or just trying to survive by doing what we can to submit what is needed.

It is significant that some institutions have started to incorporate *screening tools* for behavioral and social determinants of health within their electronic health systems. Furthermore, these will be acknowledged as key factors for billing purposes when assessing for complexity.

These tools ask a list of questions that span a variety of psychosocial issues.

Behavioral Health includes mental health issues such as depression and anxiety disorders. Social Determinants of Health (as outlined by the Office of Disease Prevention and Health Promotion¹) includes:

- Economic Stability
- Education
- Social and Community Context
- Health Care
- Neighborhood and Built Environment

Use of this screening tool seems like a valuable intervention, but one key reality remains: **a tool is only beneficial if it is used.**

How do providers that want to ensure they are taking this important step towards equitable care, use these screening tools efficiently? By following these four steps:

1) **Ask the questions:** The first step is to

document the answers to these questions, but this may not always be done. Although most locations expect their nursing/rooming staff to ask these questions, it may be a new step and easy to forget, or the importance may not be recognized. Reviews indicate that few physicians actually report their patients were screened.

Training and staffing constraints are often reported as key barriers. Given such challenges, it might be invaluable to automate the process so that patients who have internet access can answer questions prior to their visit, but many patients are constrained by problems with literacy and internet connectivity. For patients with these constraints, which are more common among some minority populations, printed handouts that can be completed while they are waiting can be useful, so that valuable time to ask questions verbally can be reserved for patients who do not complete the printed form. It is vital to provide adequate initial training and follow up with staff members who omit this screening step in the clinic.² Providers should also receive training so they are equipped to understand and administer the tool if they need to.

The timing of administering this tool will vary among practices, but in addition to annual check-ups or when a physical examination is performed, it should be considered during visits for problems that have a significant burden of morbidity and mortality, whether acute (e.g. COVID-19) or chronic, e.g. diabetes, especially when uncontrolled. At some institutions, certain screens for social need may be implemented automatically when test results are reported, but this plan may break down if additional social needs exist at the time of the clinic visit and are not captured, or if they develop after that clinic assessment, or if the patient has been tested at an outside facility.

Emphasizing which patients need the screens during the huddle process at the start of the workday can facilitate utilization. If it is recognized during a visit that these

issues need to be addressed, the provider should complete the assessment, or work with the nursing staff to do so.

As highlighted by the Center for Healthcare Strategies (CHCS),³ there may also be barriers in how information is collected. Staff may be uncomfortable asking certain personal questions, and some minorities may seem skeptical about the rationale for the questioning. To help staff be comfortable and effective in dealing with such patients, it may be helpful to provide motivational training about interviewing, or instruction in the use of phrasing that is sensitive to the patient's reluctance, such as "Some of this information can help us take better care of you."

2) Review the results: Review of the responses gathered in the tool typically takes only a couple of minutes. Though this time can be precious to some, it can provide significant benefit. The time it takes to be aware of certain psychosocial issues may make it easier to formulate a plan that is not only realistic, but also minimizes return phone calls and non-compliance, all of which will benefit not only the patient, but the clinician as well.

3) Address the issues: The next step is to address the issues that have been identified. Optimally this would occur during the current visit, so the intervention can start soon, or it could be done with another visit if it requires more time

and coordination.

Resources that should be utilized include referrals that are placed as orders and/or listed for the patient in the discharge summary electronically, or provided as a handout. Optimally, a list of resources or social service hubs that the patient can be referred to for further assistance should be available to the clinician. Social workers and clinical supervisors can clarify other resources, so they are not overlooked because they are unknown. These resources can be key for patients who refuse behavioral or social work intervention, or in locations that do not have access to them.

4) Follow up: Following up with a call from a nurse, or at a follow up visit, can be helpful in ensuring that the intervention occurred, or as an opportunity to address any additional barriers.

SUMMARY

As a society, it is time for us to start reflecting on what we can do to decrease and ultimately to eliminate social disparities in our communities, especially when they involve how one lives and dies. As clinicians who are at the forefront of addressing a patient's health needs, the use of screening tools for behavioral and social determinants of health not only assists us to be more fairly compensated when we make that effort, but also allows us to provide equitable, and thus hopefully optimal, health care.

REFERENCES

1. Social determinants of health. Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Accessed Dec 22, 2020.
2. Narayan A, Raphael J, Rattler T, et al. Social determinants of health - screening in the clinical setting. <https://www.texaschildrens.org/sites/default/files/uploads/documents/83176%20BRIEF%20Social%20Determinants%20of%20Health%20Policy%20Digital.pdf>. Accessed Dec 22, 2020.
3. Thomas-Henkel C, Schulman M. Screening for social determinants of health in populations with complex needs: implementation considerations. <http://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf>. Accessed Dec 22, 2020.

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